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HOUSE OF REPRESENTATIVES
COMMONWEALTH *of* PENNSYLVANIA

House Democratic Policy Committee Hearing

The Evolving Epidemic: Opioids and Treatment Options

Monday, May 2nd, 2022 | 1:00 p.m.

Representative Mike Schlossberg

OPENING REMARKS

1:00p.m. Chairman Ryan Bizzarro, D-Erie
Rep. Mike Schlossberg, D-Lehigh

PANEL ONE

1:10p.m. Nancy Knoebel, Founder
Danny's Ride

Rhonda Miller, Volunteer Ambassador
Shatterproof

PANEL TWO

1:45 Dave Synnamon, Manager- Injury Prevention
Allentown Health Bureau

Abby Letcher, MD, Medical Director Primary Care Addiction Medicine
Lehigh Valley Health Network

Dr. Amie Allanson-Dundon, Clinical Therapy Services, Psychotherapist
St. Lukes University Health Network

PANEL THREE

2:20 Ellen DiDomenico, Deputy Secretary
Pa. Dept. of Drug and Alcohol Programs

Hon. Douglas Reichley, Lehigh County
Court of Common Pleas

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CLOSING REMARKS

2:55 Chairman Ryan Bizzarro, D-Erie
Rep. Mike Schlossberg, D-Lehigh

Testimony of Nancy Knoebel

Monday, May 2, 2022

PA House Democratic Policy Committee Hearing: Opioid Crisis and Medication Assisted Treatment

Thank you for inviting me to share my story. Thank you, also, for making the opioid crisis a priority for your attention and efforts. The crisis has changed my life, and that of countless others, in terrible ways. Making a dent in the problem, and its impact on others, takes intention, determination, and especially, carefully allocated financial and other resources and effective policies.

In December 2009, my son Danny Teichman returned from a semester abroad in Amsterdam and our family realized we had a serious problem. My daughter Becky and I had just been to see him over Thanksgiving, and we didn't like what we saw. Danny's dad, Rob, had been to see him just before us and was also concerned by what he'd seen. What we'd thought (and hoped) was a youthful dabbling with alcohol and drugs apparently had morphed into something serious. Danny's behavior upon his return removed all doubt that something needed to be done.

Fighting us all the way, Danny entered inpatient treatment at the Caron Foundation in Wernersville. A very expensive undertaking, the 28-day program was not covered by our insurance and had to be paid out of pocket. That was followed by 6 months in a halfway house in Scranton, followed by a sober living apartment and a job for several months. Eventually, Danny was ready to go back to college, and he transferred to Temple, where he lived with his dad in Manayunk and completed a political science degree with honors.

Our family went through this with him, step by step. We fought, we cried, we begged. We examined our own behaviors that inadvertently supported Danny's drug use. We mourned for the sweet and happy child who had so much on the ball, who had vacated his position in favor of a young man who was in a fight with the world and needed to escape. We wanted our old Danny back. As a 21-year-old man, Danny did not think he needed help, and was angry with us for treating him as an addict. But he cooperated with his plan and stayed sober, for the most part.

In August 2014, we were on a family vacation, celebrating my mother's 85th birthday. Danny seemed out of it the whole time – tired, quiet, uncomfortable in his skin. By then, we'd had 5 years of Danny living in recovery, sober, productive, seemingly happy and 'his old self.' Finally, I asked him what was going on. He acknowledged that he'd become addicted to heroin and was in withdrawal. He'd been trying to quit for some time now, and had been seeing an addictions therapist, but was having a really hard time getting sober.

Danny moved back home, enrolled himself in intensive outpatient services at Mars treatment center in Bethlehem, and went on Suboxone, a form of MAT. The suboxone turned things around for him, very quickly. By taking suboxone, combined with an enormous personal commitment to recovery, Danny was able to stop using heroin and other opiates, and start working on getting his life back on track. And healing his brain, which had been hijacked by the drugs.

By December 2014, Danny opted to move to Portland, Oregon, where his dad was then living. He moved in with his father, got a job, and became deeply connected to the recovery community there. This began 2 years of sobriety, of finding himself, and healing. He had a large group of friends both "from the

rooms" and from work. He'd found a way to be sober and still socialize with people from the broader community, even though that was tough as a young adult in a town that worships beer and where pot is legal. He'd started a relationship with a lovely young woman. He volunteered with people who were homeless, providing technology support to help them keep in touch with family members, work on resumes, and access community resources. He loved the northwest and spent hours hiking and enjoying the majesty that part of the country has to offer. He was still using suboxone and was staying clean. He was happy.

Becky and her boyfriend moved out to Portland, and the three of them got an apartment in the summer of 2016. By then, Danny had stopped taking suboxone. Danny had a feeling, or thought, that using MAT was somehow cheating as far as sobriety goes. Were his days, months and years true sobriety? Whether this was an internal conflict, or peer driven, I don't know. Regardless, it was on his mind. He was on a very low dose of suboxone at the time and wanted off completely. He spoke with his therapist and the doctor he saw for the suboxone, and they came up with a plan. In the Spring of 2016, Danny quit the suboxone. He was prepared for the initial period of withdrawal, and hunkered down, got through it with the support of family and friends. That summer, he found an apartment in a fun part of Portland, and soon after Becky and her boyfriend joined him there. They had a great time living together and created many wonderful memories. In the fall, Danny quit his job to enroll full time at Portland State University, working on a master's degree in data analytics. He was really enjoying this dramatic change in focus, and excited about the work he would be able to do once he completed his degree.

What Danny hadn't counted on when he quit the suboxone was Post-Acute Withdrawal Syndrome, or PAWS. This is a secondary phase of withdrawal, typically much milder than the first phase, but it can crop up unexpectedly for months after discontinuing use. I have read that managing PAWS in people who have gone off of Suboxone is something that is part of care now, at least for some doctors. But Danny did not receive any help with it. He tried to push through on his own. One of the most disturbing symptoms he had was insomnia. Needing to be up early, ready to participate in challenging classes, Danny found what we believe he thought was a safe and natural remedy: Kratom. Kratom is an herbal extract that comes from the leaves of an evergreen tree grown in Southeast Asia. It is widely and legally available in the United States, and Danny had no problem finding it. He took it one night to help mitigate the impact of the PAWS-related insomnia, and well, he never woke up. That was the evening of November 10th, 2016. In one week, he would have celebrated his 28th birthday. We saw, next to his bed, a glass of water that had a substance mixed into it, later identified as Kratom. The Multnomah County Coroner ran a toxicology screen and determined that it was kratom that killed Danny. It worked much like heroin in that it suppressed his respiratory system. Kratom continues to be completely unregulated. Most drug tests don't test for it, and it's available in vape shops, CBD stores, gas station mini-marts, and through the mail.

Because Danny had been doing so incredibly well in his recovery, our family had no warning that he was in danger. His recovery was much more than "not using drugs." He had developed a new sense of himself, one that was based on sobriety and included dreams for the future and full engagement in the present. He was, in short, our Danny once again. Getting the call late on the night of November 11th that my daughter arrived back at the apartment that evening, and looking for Danny found him dead in bed, was every parent's worst nightmare. It was so unexpected, so abrupt, so shocking – and to use the word heartbreaking doesn't do justice to the explosion of emotions but then, there are no words to adequately convey what it's like to hear that your beloved child is dead. Out of the clear blue sky. On an

ordinary day. We didn't know what killed him so at first we imagined that he'd turned to heroin again, and OD'd. You might appreciate that one of my first thoughts was that he turned to heroin to blunt the reality that Trump had won the election. This was 2 days after the election results were in, and like us, he took the news pretty hard. It turns out that the night he took the kratom and died, he was talking with a friend, and one of his last statements was that he felt they needed to do all they could to help protect vulnerable people from the impact of a Trump presidency. Knowing Danny's heart and mind were aligned with compassion for others at the end of his life is one of the ways I know his soul is at peace. It also motivates me to put my compassion into action, to honor Danny's memory. It is at the heart of a nonprofit organization I founded, called Danny's Ride.

Danny's Ride is a nonprofit organization that provides rides to individuals living in recovery with substance use disorder. Currently operating in Lehigh and Northampton Counties, Danny's Ride is providing rides to county citizens to treatment and meetings in support of their recovery. Because Danny's Ride uses Uber and Lyft, it can be used anywhere. There are no geographical boundaries. It's a relatively new organization, founded in late 2020 with rides beginning in mid-2021, Danny's Ride has provided well over 500 rides at this point. The need is enormous. There is not one person in the recovery community I've spoken with – those in recovery and the people supporting them – who has not endorsed this plan, and the need for transportation. The challenge is, as always, securing adequate financial resources to support it. Uber and Lyft are not inexpensive but compared with the cost of not getting needed recovery services due to a lack of transportation is far more costly on every level – financial, but also the human toll. I see Danny's Ride as a need in drug courts working with clients to focus on treatment and recovery rather than jail. For individuals living in sober living communities who need to access treatment and other community resources that support sobriety such as healthy indoor and outdoor recreation and social opportunities. And the person who is ready to go to a 12-step meeting, but has no way to get there, so doesn't go, and doesn't take that first step toward saving his or her own life.

Access to transportation is a key social determinant of health. Access to health care and to community resources both link to the need for transportation. Danny's Ride does, and can do more, to address this need, and I am committed to doing what I can to help mitigate the barrier of transportation in recovery.

When he was alive, Danny was a generous giver, and a giver of rides. Since he died, I heard one story after another from friends, family members and individuals in his recovery community, about the way Danny extended himself to provide rides, a couch, a meal, an ear. I know he would be thrilled to see people getting where they need to go, to help support them in their recovery. What keeps me going is the intention to help others get and stay sober by doing this work, so their families get to keep on loving them every day, in person. I can spare them the anguish, pain and loss those of us who love Danny have to live with. And that's enough.

I appreciate your determination to help individuals affected by substance use disorder. Publicly speaking to this disease is critical to overcome the stigma, and to address it as a disease that requires and responds to critical interventions.

Thank you.

Nancy Knoebel

KRATOM A RISKY ALTERNATIVE

WHAT IS KRATOM?

Kratom is a tropical tree that grows in Southeast Asia, where its leaves are used in traditional medicine. In recent years, kratom has gained popularity in the U.S. as an herbal supplement.

People are experimenting with kratom for relaxation and as an alternative treatment for pain, mood disorders, and opioid withdrawal — all without supervision from doctors. Because kratom can cause physical dependence and isn't regulated, any use comes with real risks.

Dried kratom leaves can be brewed in tea, powdered and added to drinks, or consumed as a capsule, pill, or extract.

IS KRATOM SAFE?

KRATOM AFFECTS YOUR BRAIN.

The Food and Drug Administration (FDA) calls kratom an opioid because it contains compounds that bind to the brain's opioid receptors.[1] When taken in large doses, kratom's effects are similar to those of morphine, heroin, and other addictive opioids. When ingested in smaller doses, kratom acts as a stimulant.[2]

KRATOM IS ADDICTIVE.

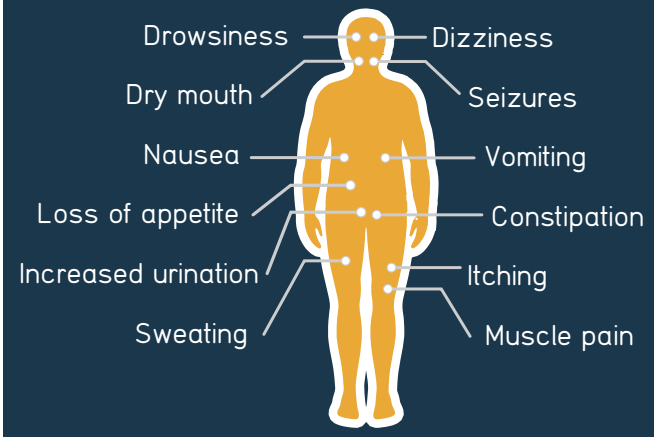
Use of kratom can cause dependence or addiction, and those with a history of addiction or substance abuse are especially at risk. If someone who has developed a physical dependence stops using kratom, they experience physical withdrawal.

Symptoms of withdrawal:

- muscle and joint aches
- insomnia
- irritability
- hostility
- watery eyes
- runny nose
- confusion
- abdominal pain
- jerky movements
- emotional changes
- nausea
- vomiting
- sweating
- anxiety
- diarrhea

KRATOM HAS UNPLEASANT SIDE EFFECTS.

Every drug has side effects, and kratom is no exception. Side effects[3] include:



KRATOM'S PURITY AND POTENCY ARE NOT CONSISTENT.

The amount of kratom in a given product is not regulated, so it can be difficult for users to control how much of the active ingredient they ingest.

The other ingredients in kratom products are also not regulated, so manufacturers can add substances that might not be safe. In testing different products, FDA scientists have discovered unacceptable levels of heavy metals like lead and nickel, as well as dangerous bacteria like salmonella.[5] Of the kratom-related deaths on record, most appear to have been caused by adultered products or users taking kratom with potent substances such as other opioids.

KRATOM IS UNREGULATED AND LEGAL, FOR NOW.

Kratom's unregulated status means it may carry risks beyond side effects and addiction.

Kratom is currently unregulated and legal at the federal level, however, due to serious health risks some state laws ban possession and use. For this same reason, the FDA and Drug Enforcement Administration are reviewing kratom to determine if its active chemicals should be classified as Schedule 1 substances and banned.[4]

LEARN MORE AT SAMHSA.GOV/KRATOM

If you or someone you know is using kratom, know that there are safer alternatives. Call **SAMHSA's National Helpline at 1-800-662-HELP (4357) or TTY: 1-800-487-4889**, or use **SAMHSA's Behavioral Health Treatment Services Locator at SAMHSA.gov** to get help.

1. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm595622.htm
2. https://www.drugabuse.gov/publications/drugfacts/kratom
3. https://www.drugabuse.gov
4. https://www.dea.gov/press-releases/2016/08/30/dea-announces-intent-schedule-kratom
5. https://www.drugabuse.gov

The Evolving Epidemic: Opioids and Treatment Options

Policy Hearing May 2, 2022

PA House Democratic Policy Committee

Hosted by
Chairman Ryan Bizarro &
Rep. Mike Schlossberg

Testimony

of

Rhonda Miller

I want to thank Rep. Mike Schlossberg for his invitation to provide this testimony to improve addiction treatment options for Pennsylvanians. My name is Rhonda Miller, and I am Ben's mom. My family and I have resided in Hanover Township, Bethlehem, Northampton County, PA for 28 years, where we raised our two boys. My purpose in sharing today is to educate those in decision-making positions about the need to remove *every barrier* in accessing Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD).

Our family knows firsthand that many barriers to MAT exist, because of our son's experience. Our beautiful boy, Ben, was an exceptional soccer player and musician, who aspired to have a career in music business management after college. Tragically, he did not complete high school or college. At 17 years old, he had his wisdom teeth removed; I advised the oral surgeon not to prescribe any strong pain medication. However, due to a botched surgery, even as a minor Ben was prescribed Vicodin to manage the pain. From what we know, this was the start of what became a horrendous addiction to opioids.

Ben sought to recover with the aid of Suboxone, which cost us $100/month even though we had private insurance. He was having great difficulty managing the opioid cravings, so I contacted the medical practice known to be the premiere addiction specialist in my area and pleaded for Ben to be seen. Once they learned that Ben was on Suboxone, he was denied treatment; they stated "your son is still on drugs. We will not see him unless he is off all drugs." The message that communicated to me was that Ben must get off Suboxone to receive treatment for his addiction. I attended Ben's monthly appointments with the local physician who was prescribing his Suboxone. The physician promised that he would gradually wean Ben off it. However, the doctor continued to prescribe, but didn't explain his reduction strategy. As I watched Ben struggle, and wither away, I finally told the doctor that Ben needs to get off

Suboxone so that he could get treatment (my experience with the premiere addiction specialist led me to naively believe that Ben could not be treated for his addiction until he was off Suboxone.) The prescribing doctor then ordered a urine screen, and once he discovered Ben had traces of marijuana and cocaine in his urine, he angrily dismissed him as a patient, and abruptly ended Ben's Suboxone prescription, cold turkey. In withdrawal, Ben turned to street heroin.

During the years of his addiction, Ben was admitted to inpatient rehabs a total of eleven times. The first nine rehabs did not offer him MAT, even though he had a serious OUD. It wasn't until his 10th rehab stint that he was offered Vivitrol. He received a monthly Vivitrol injection for two months while inpatient. When his case was reviewed by our private insurance company's medical team, they determined that Ben was "doing so well he no longer required this level of care"; and they denied payment for the balance of his inpatient stay. Ben was prematurely discharged, and even in his vulnerable state, the responsibility was placed on him to set up his medical appointments for Vivitrol maintenance, secure a full-time job, lease an apartment, purchase a car, and continue to work his recovery program. It was utterly overwhelming.

When we attempted to schedule his monthly Vivitrol injection at the time it was due, we learned the doctor licensed to administer it would be on vacation. We scrambled to find another physician who could administer it. I had to fill the script for the Vivitrol myself (costing $1,000) from a particular pharmacy in Philadelphia, and while kept refrigerated it needed to be shipped overnight. Ben could not schedule an appointment on a Monday as the Vivitrol could not be shipped Friday and remain refrigerated over the weekend. There were almost no doctors who were on the list within a reasonable driving distance from the area Ben was living. We found what appeared to be a sketchy individual, but on the list, so we attempted to schedule with the

so-called authorized physician, but he demanded cash payment upfront. It was so complicated; he would not allow us as parents to pay the bill electronically on Ben's behalf. So, I called the pharmacy and explained the situation to the pharmacist. He told me that the Vivitrol should remain in Ben's system for another week or so. We then scheduled Ben's appointment with his primary physician upon the doctor's return from vacation, which made the Vivitrol one week overdue. Ben had been experiencing intense cravings even halfway through the 30 days between injections. The night before his scheduled appointment, Ben died by fentanyl poisoning. One week before his 24th birthday.

We are DEVASTATED.

I cannot describe the immense pain, and guilt that I carry…. day in, day out…year after year…. for not being able to save my son by getting him the lifesaving Vivitrol injection within the timeframe he needed it. I will carry the burden of this guilt for the rest of my life.

My family and I are now speaking up to prevent other tragedies like our family has known. Had more physicians been able to prescribe Vivitrol, Ben likely would be here today, and I would not have to be here having this very painful conversation with you. I appreciate the opportunity to contribute to this process. As the state of Pennsylvania receives opioid settlement funding, I hope it will be used to make all the life-saving medication options for treatment of OUD available to all our neighbors, without any barriers.

Please feel free to reach out if I may be of additional service.

Sincerely,

Rhonda Miller

www.speakupforben.org

In Loving Memory of our precious son

Benjamin Alden Miller (8/8/1992 – 8/1/2016)

…We will forever SPEAK UP for BEN….

Medication Assisted Treatment

PA HOUSE DEMOCRATIC POLICY COMMITTEE

DAVID SYNNAMON, MPH ALLENTOWN HEALTH BUREAU

My name is David Synnamon and I have served in the role of Injury Prevention Manager at the Allentown Health Bureau since 2014. My work focuses on preventing unintentional injury and death from various sources including motor vehicle injuries, home injuries, falls and overdoses. I am currently the chair of the Allentown/Lehigh County Substance Use Task Force as well as the City of Allentown's Overdose Fatality Review Team.

Medication-Assisted Treatment, or MAT, is the use of medications, in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorders. These medications, in combination with ongoing behavioral counseling, curb or eliminate the cravings for opiates through either ongoing daily medication therapies or monthly injection. These drugs can either satisfy the opioid receptor in the brain without giving off a "high" or, in the case of Naltrexone, block the euphoria ad sedation generated by the central nervous system from opioid use. These are not replacing one addiction for another – these medications are utilized to ensure the patient feels and stays well – not to achieve a "high". The World Health organization has called MAT one of the "most effective types of pharmacological therapy of opioid dependence." It is effective in reducing drug use and enabling individuals to lead normal lives.

MAT has been shown to decrease opioid use and opioid related overdose deaths. When researchers studied heroin-overdose deaths in Baltimore between 1995 and 2009, they found an association between increasing availability of MAT (methadone and buprenorphine) and an approximately 50% decrease in the number of fatal heroin overdoses.

MAT can make detox easier for individuals combating substance use disorder – they must still go through the process but there are fewer withdrawal symptoms and less pain. The lessening of these symptoms combined allows patients to reach a stable place quicker and can enable behavioral therapy to begin sooner. It allows patients to have a higher success rate in their therapy as well as better outcomes with other health-related issues. MAT has also been shown to decrease neonatal abstinence syndrome in babies when pregnant mothers are participating in the therapy.

MAT also allows patients to live a functional life – they have a better chance of maintaining employment and relationships and have control over their own life.

MAT also may have larger benefits to health systems overall – a 2016 study from Vermont looked at the cost associated with MAT patients compared to patient utilizing other forms of substance use disorder treatment such as tapering, abstinence, or psychosocial interventions. The results indicated that the overall difference in annual average expenditures was lower for the MAT group, even with the cost of MAT, but not significantly lower. However, when opioid addiction treatment costs were removed, the MAT group had substantial and statistically significant lower health care costs overall compared to the non-MAT group. The reduction in cost was due, in part, to lower inpatient admissions and outpatient hospital emergency department visits among the MAT group.

Statement by Lehigh Valley Health Network

Presented by Abby Letcher, MD
Medical Director Primary Care Addiction Medicine and
Inclusion Health
Department of Family Medicine

Pennsylvania House of Representatives
Democratic Policy Committee
May 2, 2022

Contact: Mary L. Tirrell
Vice President

Government & Legislative Affairs
Mary.tirrell@lvhn.org
610-202-8052

Good afternoon, Chairman Bizzarro, and members of the Democratic Policy Committee. I appreciate the opportunity to speak with you today and want to thank Representative Schlossberg for inviting Lehigh Valley Health Network (LVHN) to speak on the importance of combating the opioid overdose crisis by improving access to medication for addiction treatment (MAT).

I am Abby Letcher, a family physician and addiction medicine specialist and a member of the Lehigh Valley Physician Group (LVPG) of LVHN. I have dedicated my medical career to finding better ways to care for those who are underserved by our healthcare systems - either economically, culturally, or those who are stigmatized, such as people with substance use conditions. It is from this vantage point that I'd like to outline some of the challenges our patients with substance use conditions face when seeking treatment, what we at LVPG have done to open more doors and with your help may be able to open more.

Our clinicians connect with people experiencing substance use conditions in many environments across our network. Our clinical experience has shown us that people with substance use concerns present to our care from all walks of life – rural, urban, poor, wealthy, insured or uninsured, well-supported or dealing with exclusion through stigma, incarceration, inability to work or inability to find housing. What all these people, our patients, have in common is a need to access healthcare that treats them with respect, offering whole-person, evidence-based care, both at times of crisis and for the rest of their lives. Lehigh Valley Health Network (LVHN) includes nine hospital campuses, three in Allentown, one in Bethlehem, one in Easton, one in east Stroudsburg, one in Hazleton and two in Pottsville, PA.; Coordinated Health, which includes two hospital campuses, nearly two dozen multispecialty locations including ambulatory surgery centers and orthopedic injury centers in northeastern Pennsylvania and western New Jersey; 27 health centers; numerous primary and specialty care physician practices; 20 ExpressCARE locations including the area's only Children's ExpressCARE; pharmacy, imagining, home health, rehabilitation and lab services,; and preferred provider services through Valley Preferred. Lehigh Valley Health Network physicians, advanced practice clinicians, nurses, case managers, social workers, and behavioral health specialists continue to train to provide person-centered care to people with substance use conditions. We continue to expand access to MAT across our acute care settings such as the emergency department and hospital settings, as well as within our primary and specialty care practices. We do a lot! And we are always looking to better care for each of the communities we serve.

As the Commonwealth experienced a growth in patients with harmful opioid use and deaths related to the deadly street supply that is contaminated with synthetic opioids, LVHN began to look for innovative ways to reach more patients in need of whole patient care that includes MAT. While we have one licensed drug and alcohol facility, Schuylkill Health Center for Counseling in St. Clair, we knew we weren't reaching the vast majority of patients who needed treatment so we began looking at the needs of patients within our own walls. In 2018 the LVHN Division of Medical Toxicology began providing MAT services in the emergency department and inpatient setting, and OB/GYN established a specialty clinic called connections to address the increasing number of pregnant women with addiction unable to find the care they needed. We partnered with local drug and alcohol programs, yet struggled to find solutions for whole person care, for a lifetime, that could increase access to MAT. We know from national studies that in communities with more primary care clinicians, people get more preventive care, cost health systems less, and live longer. We know across the country that primary care has stepped up to develop affordable, accessible, low stigma options for people who need medications for addiction treatment. We recognized that LVHN, with a strong primary care network across 7 counties, is in a strong position to increase access to life-saving care in our primary care offices so we began to focus our MAT efforts there.

We have made significant strides with our primary care offices, with support from statewide programs such as Project RAMP, PacMAT and the Centers of Excellence for Opioid Use Disorders. Our initiative to expand access in the primary care setting started with just a few primary care and obstetrics physicians. Through outreach and education efforts around medication safety, stigma, harm reduction, and a commitment to trauma-informed care, as well as the development of MAT protocols, we have expanded to 17 practices and over 2 dozen prescribers. We have hired an outstanding group of Certified Recovery Specialists, who are breaking down barriers and reducing stigma while helping each of their clients to discover their own path to recovery and community belonging. From our pioneer practices, we hear amazing stories of hope and healing.

And yet it is a challenge to keep up with the demand. As we stretch into our third year of COVID-19 and all the system transformation that a pandemic demanded, we see that overdose deaths and suicides are climbing, and the people in our community are suffering. 17 practices can make a difference, but 17 practices can't keep up alone. The losses continue to be crushing, and the demand keeps coming.

So what does it take for primary care practices to be equipped to take on this critical role in response to the overdose epidemic?

Many open doors – this takes a village. From education and prevention, to drug and alcohol treatment to recovery community support and harm reduction, we need our community to

help patients navigate to treatment and support their new lives free of addiction. Community partners need to be financially recognized and supported for what they do to decrease disparities and save lives by reaching populations traditional healthcare services don't.

We need financial support for interdisciplinary teams in our practices, including nurse care managers, social work and behavioral health, and certified recovery specialists. We need their services to be reimbursable. We need our payers to contract at reasonable rates to support fully functioning teams for collaborative care models, mental health and substance use screenings and brief interventions, and bundled monthly payment for interdisciplinary team care for Medicaid, Medicare and commercial payers.

We need our patients to have access to the medication they need, regardless of payer. That means doing away with burdensome prior-authorizations that still remain, for mono-product for pregnant women and higher doses for people who need it in the age of fentanyl, we need commercial payers to cover extended-release injectable medications, and we need funds for patients who have no insurance. We need every pharmacy to stock MAT and naloxone, in every community.

We need resources to decrease barriers to care, including payment for transportation, permanent regulation to allow tele-medicine visits for MAT, and technology in the hands of patients to allow them to access tele-health. Our patients need access to the basic survival essentials – help with housing, employment, healthy food.

We need nursing homes, recovery homes, and shelters to accept people who take medications for addiction treatment. We need more access to treatment for people who speak Spanish and for those with serious medical conditions. We need more access to treatment in jails and prisons. We need, more than anything, to let go of the stigma that keeps our patients from seeking treatment, from being able to get jobs and homes to support their families, or even keeps us from acknowledging our patients as people who deserve care and compassion.

With more and more dangerous drugs hitting the streets, access to MAT has become more important than ever in saving lives. At LVHN we have taken bold steps to develop a continuum of care, from acute care through treatment to whole person primary care for people struggling with substance use conditions. We are grateful for the support we have received through state-funded programs to improve the care we provide, and look forward to working with policy makers to find ways to make funding for treatment we know works sustainable and not dependent on grant dollars while eliminating any regulatory barriers to whole person care.

It's been an honor to address you today. Thank you for the opportunity.

OPIOID CRISIS AND MEDICATION-ASSISTED TREATMENT HEARING
HOUSE DEMOCRATIC POLICY COMMITTEE
MAY 2, 2022

Testimony of
ELLEN DIDOMENICO, DEPUTY SECRETARY

Thank you, Chairman Bizzarro and members of the House Democratic Policy Committee, for the opportunity to speak on Pennsylvania's opioid and addiction crisis and the importance of expanding access to medication-assisted treatment (MAT).

The opioid crisis has had devastating impacts on individuals and families across Pennsylvania and our nation, hitting record numbers of overdoses in 2017.

As a state, we responded deliberately and intentionally in 2018 by lowering the overdose death rate 18% from the height of the opioid crisis in 2017. As we continue to see the lasting mental and behavioral health impacts evolving from the COVID-19 pandemic, we're aware of the emergent need to provide every possible resource to combat the disease of addiction throughout the commonwealth, including the importance of expanding access to MAT.

Medication-Assisted Treatment

MAT is the use of medication, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs. Research shows that a combination of medication and therapy can successfully treat opioid use disorder (OUD), and for some, MAT can help sustain recovery.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the use of MAT has also been shown to improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity among people with substance use disorders, increase patients' ability to gain and maintain employment, and improve birth outcomes among women who have substance use disorders and are pregnant.

Buprenorphine, methadone, and naltrexone are the medications used to treat OUD. These medications are safe to use for months, years, or even a lifetime and use of these medications will reduce withdrawal symptoms and cravings for opioids and/or block the euphoric and sedative effects of opioids and prevents feelings of euphoria.

At a time when we are seeing an increase of overdose deaths across our commonwealth, the Department of Drug and Alcohol Programs (DDAP), realizes that MAT is a valuable tool in preventing and reducing opioid overdose, and is an effective method of harm reduction.

Harm reduction is a proven public health approach that minimizes the negative consequences of drug use, saves lives, improves health outcomes, and strengthens families and communities.

Expansion of MAT in Pennsylvania

DDAP has implemented a number of efforts to make MAT available across the commonwealth. One such effort is the Rural Access to Medication-Assisted Treatment in Pennsylvania project (Project RAMP). Project RAMP expands access to MAT for OUD by providing training and

technical assistance to primary care providers in rural Pennsylvania. These efforts are now being extended beyond rural Pennsylvania.

Lehigh Valley Health Network (LVHN) received support from Project RAMP to expand MAT access. Beginning in 2018, LVHN set up emergency department, inpatient, and primary care-based resources to support patients with OUD and in accessing MAT. After implementing initial acute care treatment, the team began to train primary care physicians to continue care in outpatient settings. The initiative began with just four primary care physicians and as of last spring, had 25 participating primary care providers in urban, suburban, and rural Pennsylvania.

By integrating both universal screening for substance use disorders in outpatient clinics and medications for opioid use disorders in primary care practices, stigma surrounding addiction was reduced and access to treatment made easier. To further illustrate the project's success, I would like to provide you with a few statistics:

- 100 patients a month are transferred from emergency departments and inpatient hospital units to maintenance care.
- As of 2021, 80 patients across 12 sites were receiving treatment from more than 20 providers.
- Approximately 72 percent of LVHN's patients in this program have remained in treatment after 120 days and 65 percent remained in treatment after 180 days, far exceeding the national average.

The success of Project RAMP shows that we have a golden opportunity to increase access to life-saving resources, especially in rural parts of Pennsylvania, and ultimately save more lives.

Another promising practice is the use of telemedicine to provide access to MAT initiation without delays in receiving treatment. An individual with SUD seeking treatment is significantly more likely to engage and follow through with that treatment if they do not need to wait for an appointment a few days out. The use of telemedicine was broadly available during the pandemic facilitated by temporary waivers of federal and state regulations. Permanent waivers of regulations limiting the use of telemedicine or legislation to allow the use of telemedicine are needed to allow this practice to continue.

An example of this practice is the UPMC Medical Toxicology Bridge Program. The program makes a physician who is board certified in emergency medicine, medical toxicology, and addiction medicine available within hours, rather than days, for a person seeking treatment for OUD. The individual is evaluated and prescribed appropriate medication. Navigators or Certified Recovery Specialists assist the individual in obtaining supports and follow-up treatment.

Research shows that this real-time access to treatment improves the likelihood that an individual will initiate and stay engaged in treatment. Continued treatment engagement also reduces overdoses and other medical conditions associated with OUD.

Individuals within the criminal justice system represent a high-risk population for OUD. Efforts to make all forms of MAT available during and post incarceration are essential to help these individuals move toward their own personal recovery and lead successful productive lives.

Administration Successes

Recent years have been marked by both progress and setbacks. While the setbacks can be difficult to digest, they have revealed new challenges and exposed how critical drug and alcohol prevention, treatment, and recovery programs are to the health and well-being of our fellow Pennsylvanians.

Naloxone

In addition to MAT, expanding access to naloxone has been a live-saving strategy in our fight against OUD since 2015 and leveraging naloxone as resource to save lives continues to be a top priority of the Wolf Administration. Naloxone is a medication that can reverse an overdose caused by an opioid drug. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing.

Working collaboratively with our state agency partners, stakeholders, treatment providers, and advocates we have expanded access to life-saving naloxone. Since November 2017, Centralized Coordinating Entities have distributed more than 130,000 kits of Narcan. The Pennsylvania Commission on Crime and Delinquency distributed almost 55,000 additional kits of Narcan directly to organizations serving high-need communities through its Statewide Portal. Using this state purchased naloxone, more than 20,389 overdose reversals have been reported— more than 20 thousand lives saved.

There are three main ways individuals in Pennsylvania can access naloxone: by presenting Physician General and DOH Acting Secretary Dr. Denise Johnson's standing order at a local pharmacy, watching a training video and receiving naloxone by mail through NEXT Distro, or by making a request through the Pennsylvania Commission on Crime and Delinquency's Statewide Naloxone Allocation Request Portal. This portal launched in March 2021 allows eligible organizations serving high-risk populations the ability to request additional naloxone nasal spray.

With these resources, all residents of Pennsylvania who are at risk of experiencing an opioid-related overdose, or who are family members or friends who are in a position to help someone at risk can now get naloxone, no matter what. We encourage Pennsylvanians to learn more about naloxone and consider keeping it on hand so if someone is in need, you can help save a life.

Department of Justice Guidance

The Department of Justice recently published guidance on how the Americans with Disabilities Act (ADA) protects people with OUD who are in treatment or recovery, including those who

take medication to treat their OUD. This guidance focuses on protections against discrimination in areas such as treatment, employment, housing, social service programs, courts and prisons.

The need for such guidance demonstrates the continued impact of stigma for individuals with OUD and the need for education about the importance of evidence-based treatment such as MAT.

Furthermore, I would be remiss if I did not mention the impacts of additional initiatives and strategies that we have implored and have the chance to build upon, including:

- **Assisting Individuals in Accessing Treatment**: Directly referring almost 12,500 callers to SUD treatment providers through our Get Help Now Hotline in 2021, for a total of over 38,000 referrals since 2016. The hotline has increased intakes from 40% in 2016 to 65% in 2021, indicating that more calls are resulting in connections to treatment and resources than ever before.

- **Assisting Individuals in Recovery**: To ensure individuals in recovery have a safe, supportive recovery environment, DDAP promulgated regulations in December 2021 for the licensure of recovery houses that receive funds or referrals from public sources. As of April 25, 2022, DDAP has licensed 21 recovery houses, is reviewing 23 submitted applications, and is monitoring 116 applications that have not yet been submitted but are in various stages of completion in the queue. DDAP has also recently announced funding for recovery house owners to come into compliance with DDAP licensing regulations.

- **Warm Hand-Off Implementation**: Since January 2017, warm handoff programs have been implemented in 160 Pennsylvania hospitals, accounting for over 95 percent of the total hospitals in the commonwealth. Through these programs, more than 24,000 individuals have been directly referred to treatment. A total of 6,931 warm handoff encounters took place across these hospitals from January 2021 to April of 2021 alone.

- **Centers of Excellence:** Developed in 2016, COEs were health care providers that were initially grant-funded for the purpose of improving access to MAT, coordinating physical and behavioral health care, and using care management and peer support services to keep patients engaged and supported along the continuum of care. The COEs make connections to community-based resources to address the full scope of the patient's needs, both clinical and non-clinical. COEs are designed to serve as a single point of entry to the health care and social services landscape.

  According to the Department of Human Services, an independent study of the COE program completed in 2019 compared individuals with OUD who were treated by a COE

against those individuals with OUD who did not receive treatment from showed that engagement with a COE yielded a:

  - 31% increase in engagement in treatment after receiving an OUD diagnosis;
  - 40% increase in primary care visits;
  - 22% increase in receipt of medication for treatment of OUD;
  - 11% increase in continued use of that medication for six months; and
  - 8% decrease in emergency department visits.

- **Reducing Barriers to Treatment**: Stigma associated with SUD remains to be a major barrier to an individual seeking treatment. In September 2020, Governor Wolf and DDAP announced the launch of Life Unites Us, a SUD anti-stigma campaign. It uses proven behavioral health strategies through social media platforms to spread real-life stories of individuals and their family members battling SUD, live and recorded webinars detailing tools and information necessary to more than 350 community-based organizations focused on SUD prevention, treatment, and recovery throughout Pennsylvania, and a web-based interactive data dashboard detailing the progress of the campaign. During its first year, the campaign earned more than 3.6 million impressions on social media and more than half of those who viewed the campaign reported that they feel more prepared to talk with others about stigma against opioid use disorder.

On behalf of the Wolf Administration, thank you again for this opportunity. We are committed to continuing to work with you and all members of the General Assembly to address the ongoing addiction crisis and strengthen drug and alcohol services and supports to individuals across the commonwealth.

Remarks before House Democratic Policy Committee Hearing May 2, 2022

Thank you Mr. Chairman and members of the House Democratic Policy Committee for this opportunity to address you today on the crisis of illegal opioid drugs streaming in our communities here in Lehigh County, and the use of Medication Assisted Treatment, or MAT, to aid in the recovery efforts of those affected by substance use disorder. As the members of this committee have learned, there is not any one method to assist those afflicted by addiction to opioids, and what works for one person does not mean there will be universal success with that same recovery program for everyone. MAT is just one more tool among many options to provide a path for recovery.

Here in Lehigh County, we started a drug treatment court just 18 months ago. For many years, judges with the decision – making authority in Lehigh County resisted the implementation of treatment courts on the grounds that supervision of individuals with drug addictions was adequately provided by our Adult Probation Office, and any relapses in the use of illegal drugs could be addressed in probation or parole violation hearings. I cannot identify one factor or another which led to a change in this approach by the courts, but under the leadership of then-President Judge Edward Reibman, and with the continued support of our current President Judge, J. Brian Johnson, we initiated our treatment court in the fall of 2020.

To date, we have struggled to overcome long-held objections to the type of hands-on supervision of those who are impacted by addictions to illegal drugs and alcohol which has led those persons to come within the criminal justice system. As a long-time prosecutor both here and in Philadelphia, I certainly approached my role as judge in our criminal division with a law-and-order approach. However, the statistics do not support the position that just saying no to

drugs is a sufficient solution to drug use, especially in the wake of the powerful grip of opioid medication which are flowing through many communities.

As an article in the November 17, 2021 edition of the Washington Post noted, more than 100,000 Americans died of drug overdoses in the first 12 months of the pandemic. That number is roughly the seating capacity of Beaver Stadium at State College. The number of opioid overdose deaths was a 28.5% increase over the previous year, but the scourge of illegal drugs did not start in 2020.

→ Opioids act by attaching to specific proteins called opioid receptors that are found in the brain, spinal cord, gastrointestinal tract, and other organs in the body.

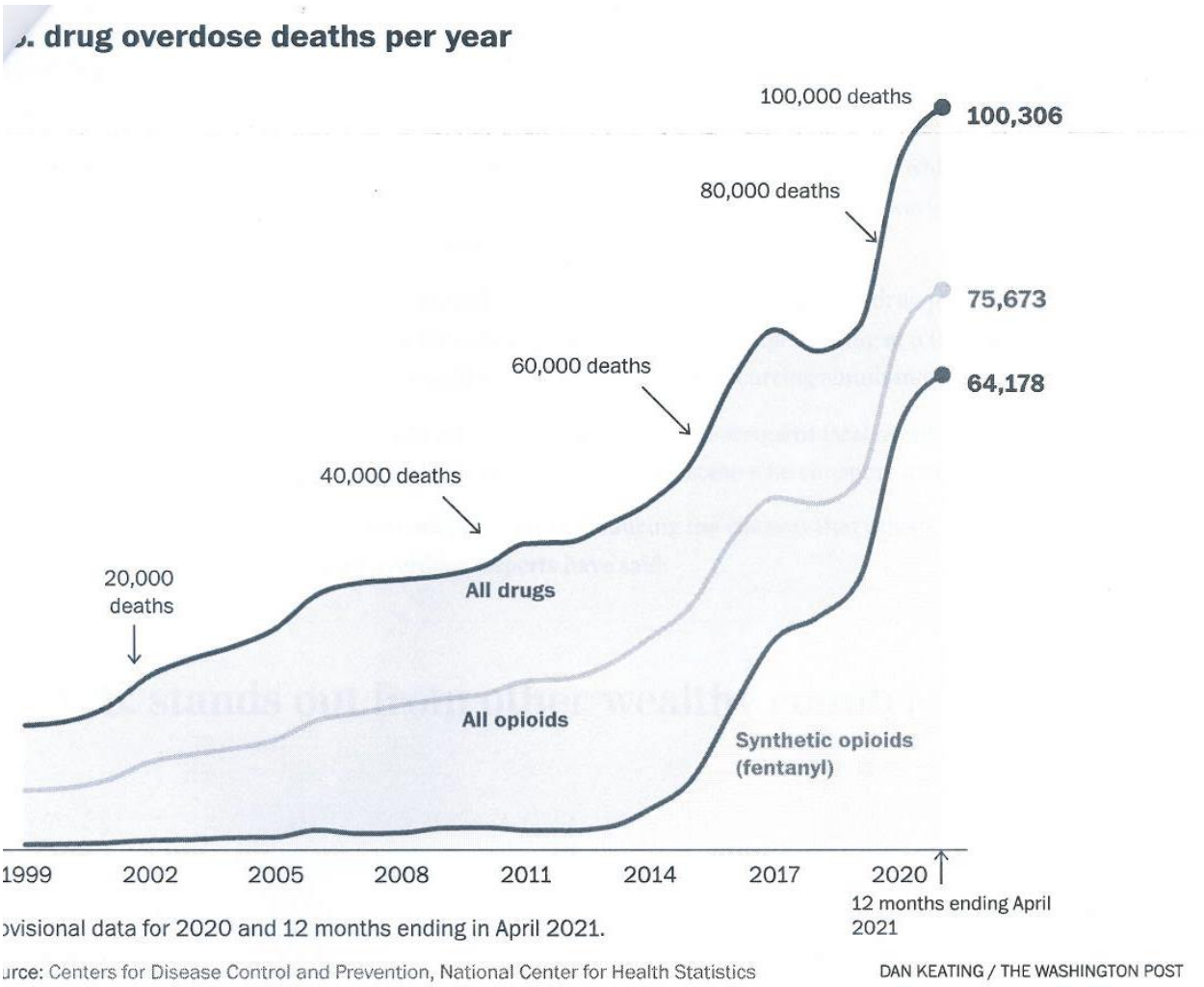
→ When these drugs attach to their receptors, they reduce the perception of pain.

→ Some people experience a euphoric response to opioid medications because these drugs affect the brain regions involved in reward also.

→ Opioids can depress breathing by changing neurochemical activity in the brain stem where automatic body functions such as breathing and heart rate are controlled.

→ Opioids can block pain messages transmitted through the spinal cord from the body.

→ Opioids can increase feelings of pleasure by altering activity in the limbic system, which controls emotions.



→ The United States is in the midst of a drug overdose epidemic…

500% increase in opioid addiction in the last 7 years. $45 billion proposed in health care plan.

→ Hospital overdose admissions in Pennsylvania have increased 66% since 2014 and 99% in the last decade.

→ The Average age of overdose patients is 33, with 70% between the ages of 20 to 39. The average age for overdose of pain medication is 54 and 60% are over age 50.

→ A report from the Pennsylvania Senate determined the economic impact on the state exceeded $53 billion in 2016. National impact is estimated to be $500 billion.

→ From 2000 to 2016 over half-a-million people in the United States died from drug overdoses. This number is expected to be over 1 million by 2020.

→ In 2016, there were approximately two times more drug overdose deaths in the United States than deaths from motor vehicle crashes.

→ Prescription pain relievers and heroin are the main drugs associated with overdose deaths.

→ Most were between the ages of 25 and 44.

→ In 2015, 33% of Americans age 18 or older were prescribed an opioid.

→ According to the CDC, in 2016 drug overdoses killed 63,632 with two-thirds involving an opioid.

→ Overdose deaths increased by 17,000 from 2015 to 2017.

Perhaps just as alarming, the Wall Street Journal published an article on March 30, 2022 citing the percentage of working Americans testing positive for drugs hit a two-decade high in 2021.

2020 Overdose Rates

- 91,799
- Leading drugs resulting in overdose deaths
  - Opioids – 68,630
    - Synthetic Opioids 56,516 (excluding methadone)
    - Prescription Opioids – 16,416
    - Heroin – 13,165
  - Stimulants
    - Cocaine – 19,447
    - Methamphetamine – 23,837
  - Benzodiazepines – 12,290
  - Antidepressants – 5,597
- 2021 (29% increase from 2020)
  - Estimated at over 104,288
  - Pennsylvania 5,465 (as of September2021)

- California 9,538
- Florida 7,579

- Pennsylvania 5,278
  - Berks had highest rate ever recorded in the county
- Ohio 5,125
- New York 5,132
- Texas 4,192
- Illinois 4,192
- North Carolina 3,260
- Tennessee 3,128
- New Jersey 2,841

From a local perspective, as the one criminal judge who handles non-ARD DUI cases in Lehigh County. I have been doing this for the last two years. Of the roughly 60 – 80 people who are scheduled for these DUI court sessions, approximately 10% show up under the influence of illegal drugs, including marijuana, heroin, methamphetamine, or fentanyl. The affliction of dependency is not limited to select racial or ethnic groups, or even by certain age and gender categories. One day I had at least two white women in their 50's who came to court high on methamphetamine, one of whom drove to court from Utah and admitted she started to use meth around Pittsburgh to stay awake while she drove. The spread of fentanyl has become so pervasive that marijuana sold on the street is found to have fentanyl laced into it, sometimes without the knowledge of the buyer.

To bring up a more immediate concern, I have been greeted two times in past week since recreational marijuana was legalized in New Jersey with defendants who came to court for their DUI cases with marijuana in their systems, based on drug testing administered by Adult Probation officers. As I said, this is not an uncommon occurrence, but what is striking was the explanation offered by the defendants who argued the presence of marijuana in their system was

due to their use of legal marijuana in New Jersey, and that they were therefore excused from any criminal culpability from coming to court with marijuana in their system.

Over the past five years, our prison population has demonstrated a concerted need for detoxification, which can begin in custody, and often with the use of MAT. If not, a defendant may suffer disastrous withdrawal symptoms. Ironically, by placing a defendant in custody and away from controlled substances for a few weeks or months, one inadvertently lowers the tolerance level of the individual to the effects of opioids purchased on the street. Once the same person relapses and starts to use illegal drugs upon release from prison, with the lowered tolerance and the possible lacing of other street level drugs with fentanyl, you place that same person at risk of a fatal overdose if the defendant has not been able to be placed on MAT while in custody. Tolerance to opioids is lost within 3 – 7 days.

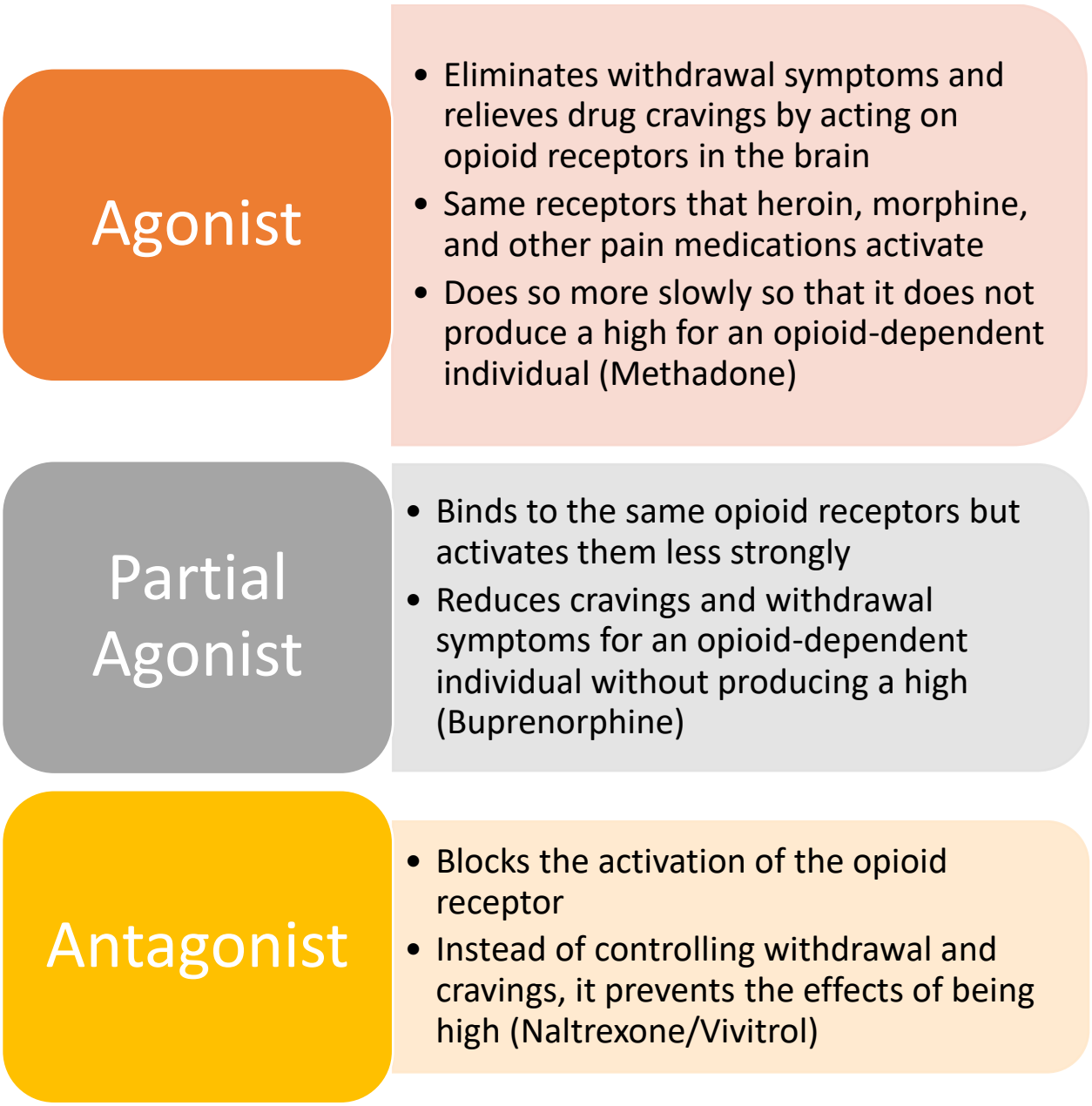
DEPARTMENT OF CORRECTIONS (ADULT SYSTEM) *continued*

733 of the 3,018 commitments (24.3%) needed to undergo medically supervised detoxification.

	2017	2018	2019	2020	2021
Heroin	309	228	208	167	202
Alcohol	335	321	394	199	192
Alcohol/Heroin	74	83	78	51	49
Opiate (Prescription)	51	61	78	46	46
Methadone	12	5	2	2	2
Benzodiazepine	76	76	65	45	37
Various Combinations	274	254	319	160	169

Points of Interest:

- The total number of commitments continues to decrease.
- While commitments have decreased, the percentage of inmates in the jail requiring detoxification for heroin has increased.
- The percent of jail population prescribed psychotropic medication has increased.
- Reductions in commitments and average daily population are due to county wide efforts to decrease the jail population during the COVID pandemic.



As the committee members know, treatment can come in many different forms based on a defendant's substance use history and risk for recidivism. As a result, traditional treatment modalities are deemed to be out of step with current best practices. Contrary to conventional treatment approaches of the past, new recommended methods include the supervision of

medication – assisted treatment, or MAT, and the use of medical marijuana as a crossover medication toward sobriety.

However, these medications should only be used in coordination with medical supervision. It is also imperative that a participant's entire medication regimen be consolidated under the care of one treating physician to ensure that participants do not substitute illegal drugs with other prescribed medications.

One of the dangers in using methadone is the potential for a treatment participant to trade one addiction for another, i.e., the defendant becomes hooked on the methadone. This why methadone is only administered in a clinical setting, while buprenorphine, suboxone, and Vivitrol can be provided to be used outside of a doctor's presence. The lingering apprehension and opposition to replacing one addictive drug with another has led some judges to preclude defendants who wanted to participate in drug treatment courts from using any other medication while under supervision. The sentiment behind having a treatment court participant "go cold turkey" may seem preferable, but the level of dependency on opioids can be so extensive that full recovery may not be achievable without the use of stepdown drugs to assist a defendant towards sobriety. There is not an intent to have a defendant develop a lifelong dependency on buprenorphine or suboxone, which is another reason these types of medications should only be prescribed under a coordinated medication plan.

While MAT is often critical to the recovery of individuals, careful monitoring of all pharmaceutical dispensation is critical. Providers and Drug Treatment Court teams must have access and refer to the Prescription Drug Monitoring Program database. This enables us to ensure that there is no abuse of medications, diversion of drugs, or doctor shopping. One of the critical pitfalls to this program is that MAT programs that dispense medications on site are

prohibited from reporting to the PDMPP that a person is taking a form of MAT, or with MAT with medical marijuana. Doctors may not know exactly what a patient is taking without full disclosure from the patient. Additionally, we can have someone who is on methadone for opioid dependence and then gets medical marijuana for the same condition. This results in over-medication and abuse of substances to continue.

Because of the opposition by some judges in several counties in Pennsylvania to allowing the use of MAT or medical marijuana in order for treatment court participants to be admitted into the recovery programs, in February, the Department of Justice informed the Pennsylvania Supreme Court that these prohibitions were deemed to be violations of the Americans with Disabilities Act on the grounds such a ban upon the use of medication to treat a disability is discriminatory. The ban is also seen as an impediment to access to court systems without a plausible explanation for a participant to be required to refrain from using medications prescribed to address a condition such as Opioid Use Disorder.

As a result of this potential court action, I believe we are at a point where the acceptance of MAT and even medical marijuana as administered within the strict confines of treatment court supervision and as coordinated by licensed medical professionals is moving from the realm of conversation among advocates to recognition and implementation as a standard among treatment courts throughout Pennsylvania. The scope of pervasive opioid use and addiction has forced court systems to at least be open to modalities with which we are not comfortable if such treatment options will hasten recovery for those suffering the most from their dependency.

Thank you for your consideration of these remarks and I would be happy to answer any questions you may have.